REFERENCES

1. Gelber RH: Leprosy (Hansen's disease), *In* Rakel RE (Ed): Conn's Current Therapy. Philadelphia, Pa, WB Saunders, 1992, pp 76-80
2. Gelber RH: Leprosy (Hansen's disease), *In* Berkow R (Ed): The Merck Manual, 16th edition. Rahway, NJ, Merck Research Laboratories, 1992, pp 146-150
3. Gelber RH: Leprosy (Hansen's disease), *In* Mandell GL, Bennett JE, Dolin R (Eds): Principles and Practice of Infectious Diseases, 4th edition. New York, NY, Churchill Livingstone, 1994 (in press)
4. WHO Study Group: Chemotherapy of leprosy for control programmes. World Health Organ Tech Rep Ser 675, 1982
5. Gelber RH, Rea TH, Murray LP, Siu P, Tsang M, Byrd SR: Primary dapsone-resistant Hansen's disease in California—Experience with over 100 *Mycobacterium leprae* isolates. Arch Dermatol 1990; 126:1584-1586
6. Meade TW, Pearson JMH, Rees RJW, North WRS: The epidemiology of sulfone resistant leprosy. Int J Lepr 1973; 41:684
7. Gelber RH: U.S.-Japan Cooperative Medical Science Program: Workshop on leprosy chemotherapy. Int J Lepr 1976; 44:369-373
8. Jacobson RR: Sulphone-resistant leprosy: Etiology, incidence and treatment in the United States. Int J Lepr 1973; 41:684
9. Pattyn SF: Search for effective short-course regimens for the treatment of leprosy. Int J Lepr 1993; 61:76-81
10. Pearson JMH, Rees RJW, Waters MFR: Sulphone resistance in leprosy; A review of 100 proven clinical cases. Lancet 1975; 2:69-72
11. Grosset JH, Guelpa-Lauras CC, Bobin P, et al: Study of 39 documented relapses of multibacillary leprosy after treatment with rifampin. Int J Lepr 1989; 57:607-614

Specialty Care Needs of a Medically Indigent Adult Population

To the Editor: Proposed changes in the national health care system include health coverage for persons currently considered "medically indigent." This group includes the 37 million Americans completely uninsured and those currently covered by state and local government-funded programs such as the medically indigent adult county medical services (CMS) programs in California.[1] Although it is clear that a strong primary care network will need to be in place, the specialty care needs of these people will be substantial.[2]

San Diego County provides physical health services to approximately 22,000 medically indigent adults 21 to 65 years old. We recently reviewed the specialty care needs of these patients and compared them with the specialists available. In fiscal year 1992, 9,202 referrals were made to 328 specialists. The burden of specialty care fell to the greatest extent on ophthalmology (22% of referrals) and orthopedics (11%). General surgery (10%) and otolaryngology (8%) were also in high demand, followed by cardiology (8%), urology (7%), and neurology (7%).

The CMS program in San Diego experiences varying participation among specialties, with only 17% of county specialists accepting CMS patients. This maldistribution results in large referral-to-physician ratios (greater than 50 referrals per physician) falling on the dermatologists, endocrinologists, neurologists, and otolaryngologists. Uneven physician participation results in administrative resources being used to find physicians to care for these patients. The proposed reforms, however, would pay physicians equally for the formerly indigent and formerly insured patients. Assuming equal participation of physicians across specialties and current utilization patterns, the referral-to-physician ratio would be realigned. These recalculated ratios are highest in the fields of gastroenterology, neurology, ophthalmology, and otolaryngology; although orthopedics, surgery, cardiology, and urology would also be in high demand, the large number of these specialists countywide would result in much lower patient-physician ratios.

Eliminating economic barriers will not result in equal access to all specialists, because of geographic, language, and cultural barriers. It is, however, refreshing to consider that true health care reform could change the attitudes towards previously medically indigent adults from a burden and duty to a sought-after patient base, eliminating the time and money spent in seeking care for these patients.

LINDA L. HILL, MD, MPH
County Medical Services Program
Medicus Systems Corporation
PO Box 939016
San Diego, CA 92193

REFERENCES

1. Friedman E: The uninsured: From dilemma to crisis. JAMA 1991; 265:2491-2495
2. Wright RA: Community-oriented primary care: The cornerstone of health care reform. JAMA 1993; 269:2544-2547

Improving Response to Domestic Violence

To the Editor: On reading Dr Patricia Salber's highly relevant epitome, "Improving Emergency Department Response to Victims of Domestic Violence," in the November 1993 issue,[1] a particular need in the care of these patients comes to mind. Working as a forensic pathologist in a coroner's office within shouting distance of the regional level I trauma center, I review emergency department records of injured patients who die. The injury assessments in these records may be adequate for treatment, but they are usually substandard for medicolegal purposes. I assume that this is also the case for many injured patients who survive and are therefore never evaluated by a forensic specialist.

In my experience, the training of emergency physicians generally is inadequate to prepare them for the task of accurately assessing injuries using proper forensic terms. Many do not appreciate the difference between a laceration and a cut, for instance. Emergency physicians often have a more pressing matter on their minds—saving the injured patient's life—and can spare little time for detailed wound evaluation and documentation. Nevertheless, injured patients should be given proper medicolegal evaluation. Inaccurate wound description can compromise treatment and may destroy the patient's right to compensation. Patients' need for justice on the criminal or civil level is as valid as their need for competent medical and surgical therapy.

Despite these farther-reaching needs, few centers in the United States have begun clinical forensic medicine training programs for residents and fellows in emergency medicine and other clinical specialties.[2] We are still far behind countries such as Great Britain, where a police surgeon—a clinician with specific forensic training and certification—is available. As a result, our quality of medicolegal evidence in cases with surviving victims, including victims of domestic violence of all sorts, is compromised.

Our forensic pathology group has offered to initiate such a program in our area, and the concept has been well received. So far, only the concept exists because funding, staffing, and other particulars are in limbo. I would encourage forensic pathologists and their clinical colleagues, along with attorneys and judges, seriously to consider the necessity of such programs in their communities. Until we establish a competent system of forensic medicine in this country, we will continue to underserve the needs of victims suffering from all forms of violence.

GREGORY D. REIBER, MD
Clinical Assistant Professor
Department of Pathology
University of California, Davis, School of Medicine
Northern California Forensic Pathology
2443 Fair Oaks Blvd, Ste 311
Sacramento, CA 95825

REFERENCES

1. Salber PR: Improving emergency department response to victims of domestic violence, *In* Epitomes—Important Advances in Clinical Medicine—Emergency Medicine. West J Med 1993; 159:599-600
2. Eckert WG: Forensic sciences and medicine. Am J Forensic Med Pathol 1990; 11:336-341

Dr Salber Responds

TO THE EDITOR: Dr Reiber's letter raises an interesting point. As emergency physicians, trauma surgeons, and other physicians caring for injured patients are becoming increasingly aware of societal violence—including family violence—as a cause of injuries, the need for training in forensic evaluation is more apparent. Such evaluation would increase our ability to diagnose violence as the cause of an injury, thereby increasing the chances for a referral or intervention to break the cycle of violence. In addition, documentation of a forensic evaluation may help injured patients who seek protection or redress in the judicial system. The best treatment of victims of violence will require a team approach. I applaud Dr Reiber's suggestion that forensic pathologists should be added to the team.

PATRICIA R. SALBER, MD
President
Physicians for a Violence-Free Society
San Francisco General Hospital
Bldg One, Rm 306
1001 Portrero Ave
San Francisco, CA 94110

The Editors are pleased to receive letters commenting on articles published in the journal in the past six months, as well as information or short case reports of interest to our readers. ALL MATERIAL SUBMITTED FOR CONSIDERATION MUST BE DOUBLE-SPACED. Letters NO LONGER THAN 500 WORDS are preferred. An original typescript and one copy should be submitted. All letters are published at the discretion of the Editors and subject to appropriate editing. Those of a scientific nature will be peer reviewed. Authors should include information regarding conflict of interest, when appropriate ("I warrant that I have no financial interest in the drugs, devices, or procedures described in this letter"). Most letters regarding a previously published article will be sent to the authors of the article for comment. Authors of accepted letters will have an opportunity to review the edited version before publication.